Delaware Health and Social Services
Division of Health Care Quality, Office of Long Term Care Residents Protection
DELAWARE NURSE AIDE APPLICATION FOR RECIPROCITY

PAGE 1 - GENERAL INFORMATION

PART I: Eligibility - A nurse aide from another state may apply for certification to the Delaware Nurse Aide Registry in lieu of completing a State Approved Nurse Aide Training and Competency Evaluation Program by meeting the following qualifications:

1. Be currently listed on another State's Nurse Aide Registry current/active and in good standing. You must have a current/active GNA certification if coming from the State of Maryland.
2. Have no pending or substantiated findings of adult/child abuse, neglect, financial exploitation, and/or misappropriation of resident/patient property recorded on another State's Nurse Aide Registry.
3. Have either been employed as a Certified Nurse Aide for at least 3 months full time (or at least 420 hours if you work part time or per diem). You must have worked for pay, under the direct supervision of an RN, APRN, PA, or MD, **or** have completed a CNA Training Program of at least 150 hours (75 hours Classroom, 75 hours Clinical).

PART II: Instructions - The following is a detailed checklist of required items:

☐ 1. **Page 2** Application for Reciprocity: Must be completed by the applicant/CNA. **PLEASE PRINT LEGIBLY**. Please sign the bottom of the page verifying that the information provided is accurate. Please answer ALL questions. **Incomplete forms will be returned. Forms with white out will not be accepted.**

☐ 2. **Page 3** Employer/Training Program Attestation Form: To be completed by a current or previous employer or training program verifying employment and/or training. **This form is NOT to be completed by the CNA**. You must have worked in a health care setting as a CNA under the direct supervision of an RN, APRN, PA, or MD. **Pay stubs, W-2s, and Time and Attendance Records will NOT be accepted for verification of employment.** Training Program verification from your CNA Training Program Administrator must verify at least 150 hours of training (75 hours Classroom, 75 hours Clinical). Please submit original form; copies will not be accepted. **Forms with white out will not be accepted.** Completed forms **must** be notarized.

☐ 3. Provide verification of certification from the State in which you are currently certified; if certified in more than one State please provide verification from all States. You must list **ALL** States in which you have **ever** been certified whether currently active or inactive, however, you do not need to send verification from States where you are inactive.

☐ 4. A legible photo copy of a Government Picture ID that shows your full (legal) name and your Date of birth.

☐ 5. The Processing fee is $30, should be in the form of a check or money order made payable to: **STATE OF DELAWARE**. We do not accept cash, credit or debit cards. All fees are non-refundable if your application is denied for any reason.

MAIL COMPLETED APPLICATION ALONG WITH ALL ATTACHMENTS TO:
DHSS Division of Health Care Quality
Office of Long Term Care Residents Protection
Attn: Erlease Freeman, CNA Compliance Nurse
3 Mill Road, Suite 308 Wilmington, DE 19806

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PAGE 2: TO BE COMPLETED BY NURSE AIDE (*Must be GNA if from the State of Maryland)

Instructions: Type or print (legibly). Your original signature is required; photocopies of this form will not be accepted. Forms with white out will not be accepted.

LAST NAME: _____ **FIRST NAME:** _____
MIDDLE NAME: _____
Applicant's name should match name as it appears on your State's CNA Registry. If different from Photo ID please provide documentation.

SOCIAL SECURITY NUMBER: _____
CURRENT CNA CERTIFICATION NUMBER: _____ **STATE:** _____
Please list ALL states in which you have EVER been certified whether currently active or inactive (must provide verification of all *active* certifications): _____ _____ _____ _____ _____

DATE OF BIRTH: _____/_____/_____ **GENDER: Male___Female ___**

MAILING ADDRESS: _____ **CITY:** _____
STATE: _____ **ZIP CODE:** _____
DAY TIME PHONE #: _____ **EVENING PHONE #:** _____ **EMAIL ADDRESS:** _____

PLEASE CIRCLE THE APPROPRIATE ANSWER:

1) Is your current State certification in good standing (i.e. no pending or substantiated findings of adult/child abuse, neglect, financial exploitation and/or misappropriation of resident/patient property)? **Yes No**
If NO, give details on a separate sheet

2) Have you **EVER** had a negative finding entered against you on **ANY** State registry? **Yes No**
If YES, give details on a separate sheet

3) Have you **EVER** been convicted of a criminal offense including any guilty pleas and/or no contest pleas? **Yes No**
If YES, give details on a separate sheet

4) Have you worked in a healthcare setting as a CNA for at least three months full time or at least 420 hours [for pay] under the supervision of an RN, APRN, PA, or MD? **Yes No**
If YES, please have Section 1 of Page 3 completed by your employer, and attach. If no please answer question #5

5) If you have NOT worked for at least three months full time and/or don't have at least 420 hours, have you completed a CNA Training and Competency Evaluation Program of at least 150 hours? (75 hours classroom, 75 hours clinical) **Yes No**
If YES, please have Section 2 of Page 3 completed b your training program, and attach. If no please call 302-421-7410 for instructions.

***I certify that all information provided in this application is true. I understand that my application may be denied for submitting false and/or fraudulent information.**

Signature of Applicant: _____ **Date:** _____

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PAGE 3: EMPLOYER/TRAINING PROGRAM ATTESTATION FORM

Applicant's Full Name (As listed on Page 2): _____ **DOB:** _____

1. This form is to be completed by the Employer or Training Program Administrator. Applicants please enter (only) your name and date of birth above. Forms must be notarized; if there is no licensed notary in the facility, please submit verification on official company letterhead. Please remember that photocopies of this form, and forms with white out will **NOT** be accepted.
2. Pay stubs, W-2s, and Time and Attendance Records will **NOT** be accepted as proof of employment. Please include a copy of your Training Program Certificate of Completion for Section 2

EMPLOYER or TRAINING PROGRAM NAME: _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____ **CONTACT NUMBER:** _____

Complete either Section 1 or Section 2 below:

Section 1

AS THE EMPLOYER, I certify that the individual named above is/was employed as a CNA and worked FULL TIME from (mm/dd/yyyy)_____ to (mm/dd/yyyy)_____ under the supervision of an RN, APRN, PA, or MD. I am not aware of any disqualifying misconduct.

OR...

AS THE EMPLOYER, I certify that the individual named above worked PART TIME or PER DIEM as a CNA for a total of _____ hours under the supervision of an RN, APRN, PA or MD. I am not aware of any disqualifying misconduct.

Print Name: _____ Signature: _____

Title: _____ Date: _____

Sworn and subscribed to me on this_____day of_____, 20____, in _____ County, In the State of ____.

Print Name: _____ (Place Notary Seal Here)

Signature: _____

Section 2

AS THE TRAINING PROGRAM ADMINISTRATOR, I certify that the individual named above completed a Nurse Aide Training and Competency Evaluation Program on _____. The Program was a total of _____hours (_____ hours class/theory, _____ hours clinical).

Print Name: _____ Signature: _____

Title: _____ Date: _____

Sworn and subscribed to me on this_____day of_____, 20____, in _____ County, In the State of _____.

Print Name: _____ (Place Notary Seal Here)

Signature: _____